

Living Well Chiropractic, Inc.

3786-E Farris Bridge Rd. Suite E, Easley, SC 29640

Phone: 864-246-5554

Fax: 864-246-5569

Date _____ Name _____ Nickname if used _____

First, Middle, Last Names

Mailing Address _____ City _____ State _____ Zip-code _____

Include street type such as St., Ave., etc.

Physical Address (If different from above) _____ City _____ State _____ Zip code _____

E-mail address/Pager _____ Phone # () _____ Cell Phone () _____

Fax () _____ D.O.B. _____ Sex _____ SS#: _____

Marital Status _____ Children's names and ages _____

Name of nearest relative (not your spouse) _____ Phone _____

If Student: Status: Full time _____ Part time _____ School _____

Employer _____ Status: Full time Part time Retired Not employed

Work Mailing Address _____ City _____ State _____ Zip Code _____

Work Phone () _____ Extension _____ Work Website _____

How did you hear about us? _____ Yellow Pages _____ Talking Phone Book _____ Pickens Sentinel _____ Easley

Progress _____ Coupon _____ Road Sign _____ Other _____ Referral _____

Medical Insurance _____ Insurance Phone #() _____

Policy ID # _____ Group # _____ Primary Insured (If different than patient) _____

Primary Insured D.O.B. _____ Primary Insured's Mailing Address (If different than

patient) _____ City _____ State _____ Zip Code _____

Primary Insured's Employer _____ Mailing Address _____

City _____ State _____ Zip Code _____

Is your visit due to an accident? (Auto or work) No Yes (If yes, please see receptionist for an injury report.)

Since your symptoms began, have you noticed a change in :

Bowel Function

Bladder Function

No change

Is there pain when you cough or sneeze? If yes, Where: _____

Do you have headaches? Y N If yes, describe: _____

First Complaint:

- Date when symptom first appeared _____
- Did it begin _____ Gradually _____ Suddenly _____ Progressively over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Yes _____ No
- How often do you experience these symptoms?
 _____ 100% _____ 75% _____ 50% _____ 24% _____ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.
 No Pain _____ Unbearable Pain

Other Complaint:

- Date when symptom first appeared _____
- Did it begin _____ Gradually _____ Suddenly _____ Progressively over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Yes _____ No
- How often do you experience these symptoms?
 _____ 100% _____ 75% _____ 50% _____ 24% _____ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.
 No Pain _____ Unbearable Pain

Medical History

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____
 Type of Treatment or drugs prescribed _____

Name of Treating Physician _____ Dates of Treatment _____
 Type of Treatment or drugs prescribed _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe condition _____ Date of last physical exam _____

Please list all past surgeries:

Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____
Type _____	When _____	Doctor _____

Please list all previous accidents and falls:

What _____	When: _____
What _____	When: _____
What _____	When: _____
What _____	When: _____

Please list any medications or vitamins you are currently taking:

Are you allergic to any medication? Yes No. What kind? _____

If any of the following conditions are relevant to your medical history, please check accompanying box:

- | | | | |
|-------------------------------------------------|--------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Aids | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Concussion | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nausea | <input type="checkbox"/> HIV/ARC | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Pass out easily | <input type="checkbox"/> Numbness on | <input type="checkbox"/> Arthritis Trouble | <input type="checkbox"/> Balance Problems |
| <input type="checkbox"/> Difficulty w/speech | on one side of | <input type="checkbox"/> Venereal Disease | |
| <input type="checkbox"/> Gallbladder | your face and body | | |

If Female: Are you pregnant? Yes No

Date of last menstrual period _____

Permissible to leave message with detailed information	_____ Home	_____ Work
Permissible to leave message with call back number only	_____ Home	_____ Work
Permissible to mail written communication to my home address	_____ Yes	_____ No
Permissible to be adjusted in an open area	_____ Yes	_____ No
Permissible to exercise & traction in an open area	_____ Yes	_____ No

Permissible to release medical information, when requested, to the following (please list names):

_____ Spouse or significant other _____

_____ Family member _____

_____ Other _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
(print name) (print name)

have read and fully understand the above term of acceptance and hereby grant permission for my child to receive chiropractic care.

(signature)

(date)

Pregnancy Release

This is to certify that to the best of my knowledge I am/am not pregnant and that Dr. Owens has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period: _____

(signature)

(date)

I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Living Well Chiropractic extends credit to me and I also understands that if suspend or terminate my care and treatment. Any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctor(s) at Living Well Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorized the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct. "PLEASE NOTE": There will be a \$30.00 return checks fee and 45% charge for any unpaid balances required to be sent to collections. Patients with scheduled appointments, not showing up for Massage therapy will be charged for no-show.

Signature of Patient (Patient or Guardian if patient is under 18)

Date

If you have Insurance, please read and sign the following:

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Living Well Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, choice in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonable expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement

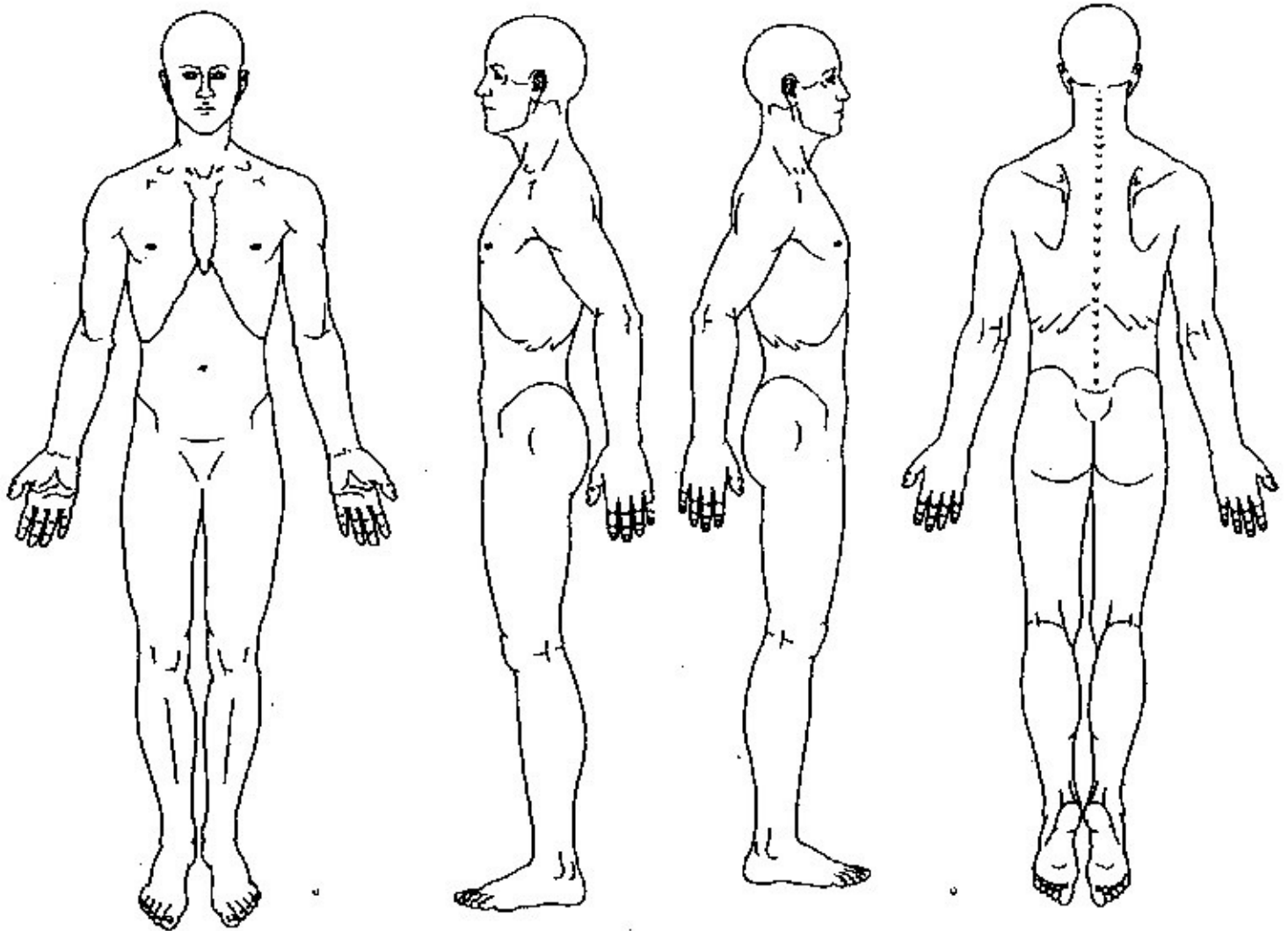
Signature of Patient (Patient or Guardian if patient is under 18)

Date

PATIENT HISTORY

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PAIN LOCATION



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

- | | |
|------------|--------------------------------------|
| PPP | Where you experience Pain |
| NNN | Where you experience Numbness |
| TTT | Where you experience Tingling |
| BBB | Where you experience Burning |
| CCC | Where you experience Cramping |

PATIENT SIGNATURE _____

DATE _____